Carrier Enrollment & Payment Process Guide

Version 1.0

Individual Market

November 15, 2012

Table of Contents

1. Introduction

1.1. Document Purpose

This Process Guide is intended to clarify the enrollment and payment business process expectations and the related transmission of information on HIPAA transactions between the Washington Health Benefit Exchange system, Washington Healthplanfinder (Exchange) and its trading partners, including health carriers and standalone dental plans. The Exchange defines trading partners as covered entities that either submit or retrieve HIPAA batch transactions to and from the Exchange System.

Revision History

DATE	REVISION NUMBER	REVISION DESCRIPTION
11/05/2012	1.0	Initial version
09/10/2012	Draft	Draft version for Carrier Review

Amendments to this process guide will be communicated to carriers prior to the finalization of decisions and will be formally issued on the Exchange website at least 30 days prior to the effectuation of changes.

1.2. Intended Users

The Process Guide is intended for account managers and staff of the enrollment, payment processing, and supporting technical staffs of trading partners who are responsible for electronic transaction with the Exchange.

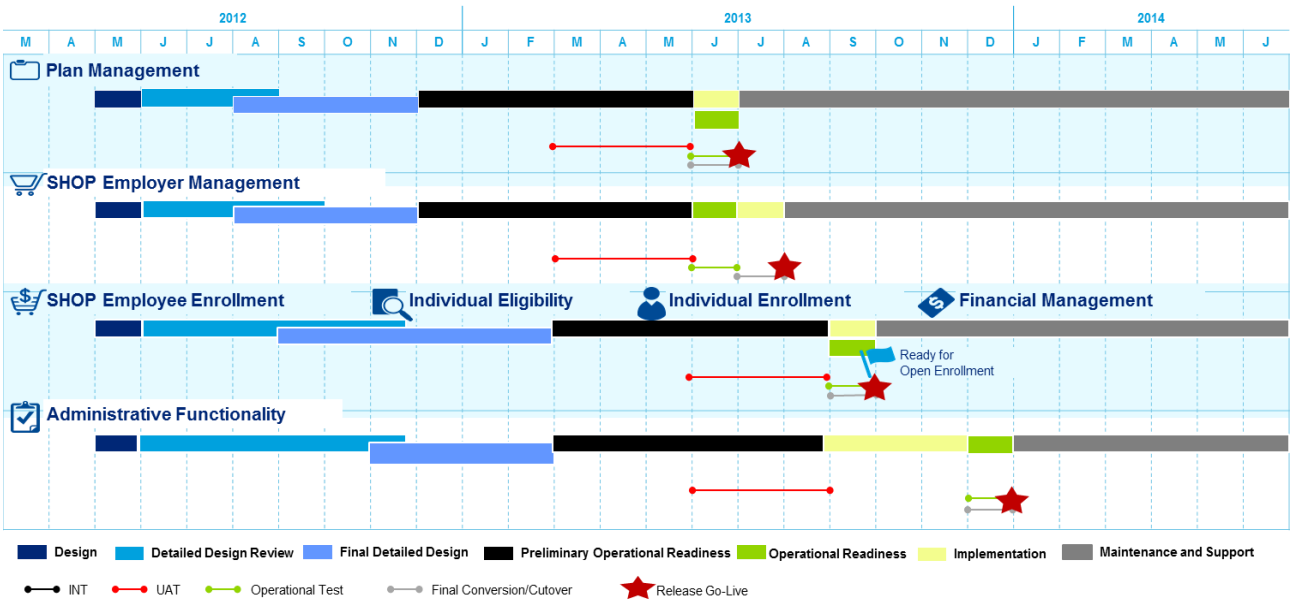
1.3. Relationship to Implementation Guides

The Process Guide is intended to supplement rather than replace the standard Implementation Guides. Rules for format, content, and field values can be found in the Implementation Guides. The 834 Enrollment and 820 Payment formal Companion Guides will be released at a later date.

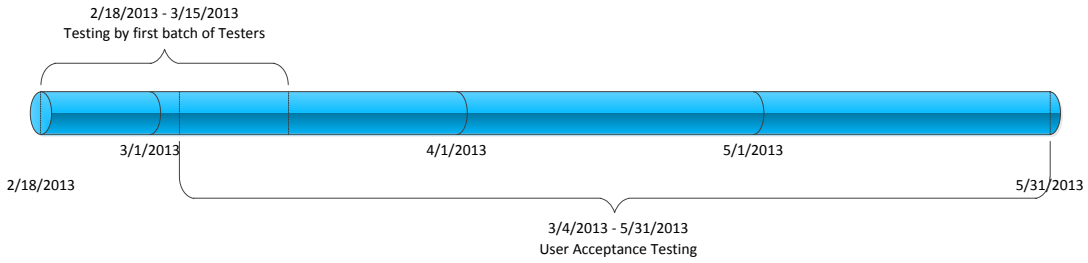
1.4. Washington Healthplanfinder Implementation Timeline

The Exchange IT implementation timeline describes the planned design development and testing phases for the Exchange project. The Exchange will implement a tiered approach to begin business partner testing. Business partners who choose to participate will be organized into three groups who will have tiered testing begin dates as described in detail below. This testing will allow adequate time for any adjustments to be made prior to initial open enrollment beginning on October 1, 2013.

Washington Health Benefit Exchange
Project Phases & Implementation Timeline



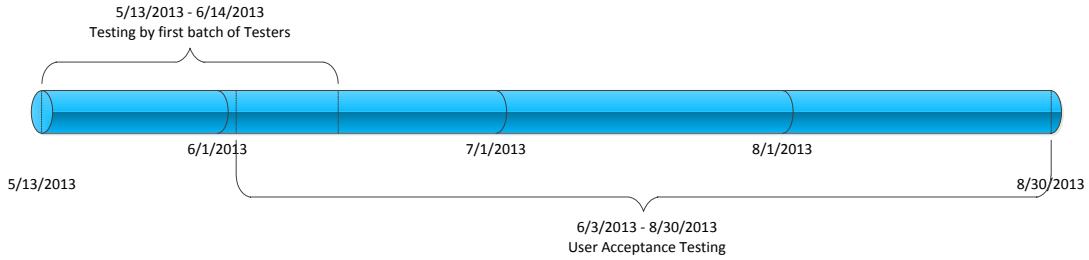
Plan Management Release – Issuer Testing Approach



Plan Management Business Partner Test Groups

Test Group 1 – March 2013
Test Group 2 – April 2013
Test Group 3 – April 2013

Open Enrollment Release – Issuer Testing Approach



Open Enrollment Business Partner Test Groups

Test Group 1 – April 2013
Test Group 2 – June 2013
Test Group 3 – July 2013

1.5. Compliance with state and federal laws

Carriers are expected to comply with all state and federal laws, including but not limited to the Patient Protection and Affordable Care Act and Title 48 of the Revised Code of Washington.

2. Technical Infrastructure and Procedures

2.1. Technical Environment

2.1.1. Setup, Exchange Contact Information

Trading partners can contact don.cotey@hca.wa.gov with technical questions.

2.1.2. Transport Protocols

The Exchange will send and receive 834 and 820 Transactions using Secure File Transfer Protocol (SFTP).

The Exchange is exploring Web Services as a transport mechanism.

2.1.3. Testing Process

Completion of the testing process must occur prior to production electronic retrieval from the Exchange system. Testing is conducted to ensure transactions meet X12 guidelines.

2.2. Set-up, Directory, and File Naming Convention

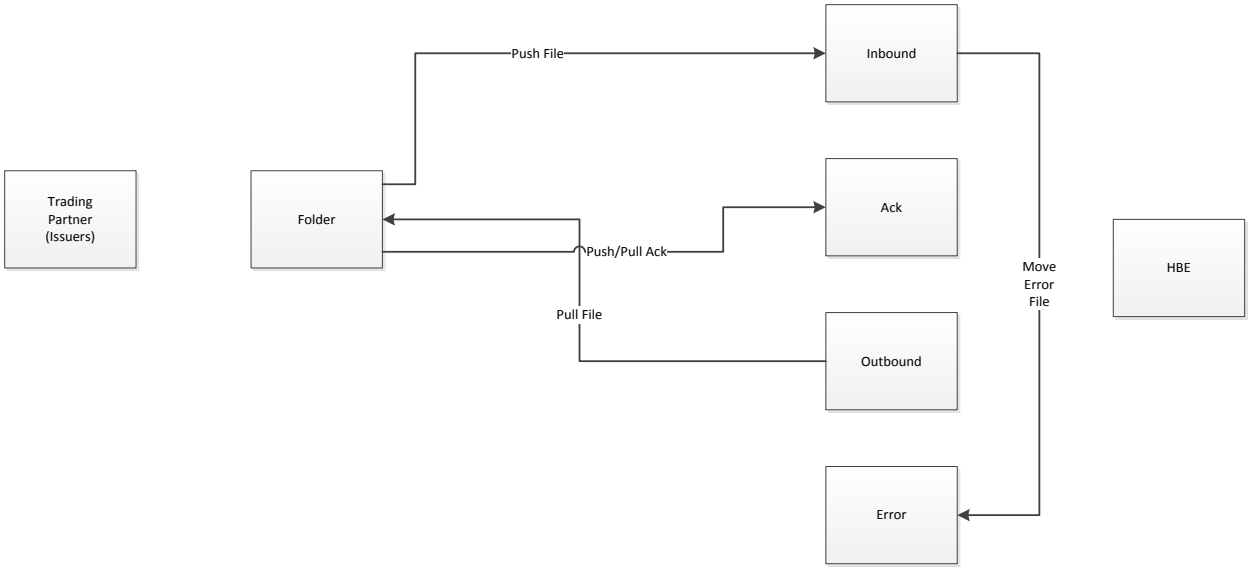
2.2.1. SFTP Directory Naming Convention

There would be two categories of folders under Trading Partner's SFPT folders:

1. TEST – Trading Partners should submit and receive their test files under this root folder
2. PROD – Trading Partners should submit and receive their production files under this root folder

The following folders will be available under the TEST/PROD folder within SFTP root of the Trading Partner:

- 'Inbound' - This folder should be used to drop the inbound files that need to be submitted to the Exchange
- 'Ack' - Trading partner should look for acknowledgements to the files submitted in this folder. 999 and custom error reports will be available for all the files submitted by the Trading Partner
- 'Outbound' – X12 outbound transactions generated by the Exchange will be available in this folder
- 'Error' – Any inbound file that is not ASC X12 compliant or is not recognized by the Exchange will be moved to this folder



2.2.2. **File Naming Convention**

The following file naming conventions are used:

For Outbound transactions:

<TPId>.<market>.<QHPId>.<datetimestamp>.<TxID><Frequency>.<O>
Example of file name: 165760000.I.1234.12262012211315.820.M.O

<TPId> is the Trading Partner Id

<Market> is "I" for the Individual market and "S" for the SHOP market

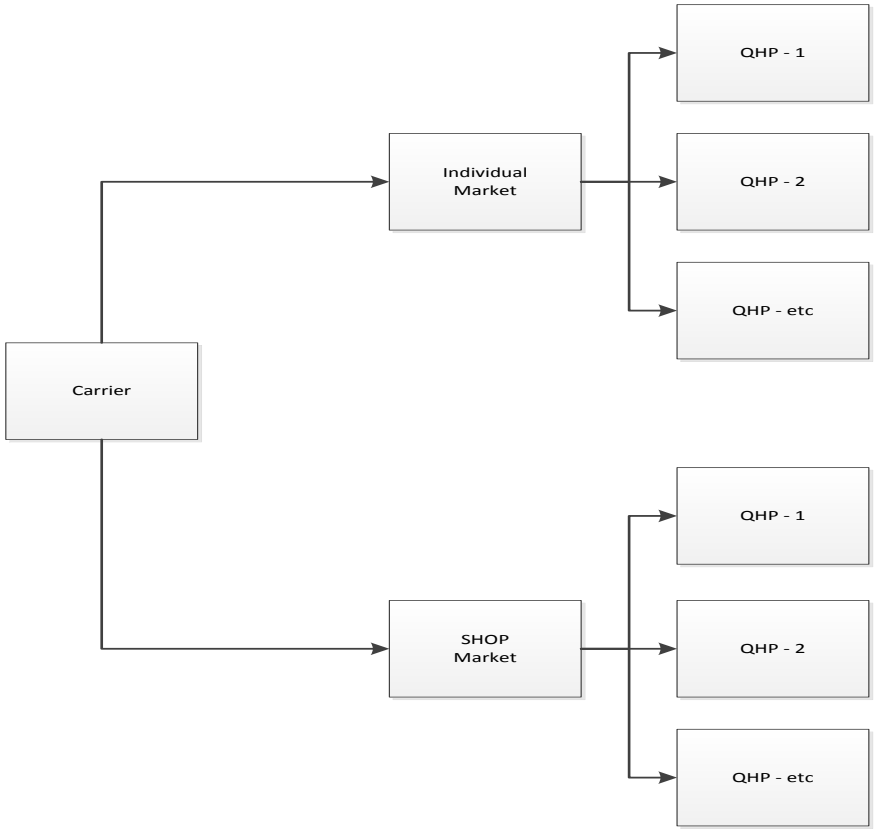
<QHPId> is the QHP Id

<datetimestamp> is the Date timestamp

<TxID> is the Transaction Id

<Fequency> is either "M" for Monthly or "D" for Daily

<O> signifies outbound transaction



2.3. Transaction Standards

2.3.1. **General Information**

ASC X12 standards are specified in the Implementation Guides for the 834 Benefit Enrollment and Maintenance guide dated June 2010 and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products dated February 2007
The 820 is ASC X12N/005010X218.
The 834 is ASC X12N/005010X220A1.

An overview of requirements specific to each transaction can be found in the 834 Enrollment and 820 Payment Implementation Guide. Implementation Guides contain information related to:

- Format and content of interchanges and functional groups
- Format and content of the header, detailer and trailer segments specific to the transaction
- Code sets and values authorized for use in the transaction
- Allowed exceptions to specific transaction requirements

2.3.2. Data Format

Delimiters

Exchange recommends the ASC X12 standard delimiters:

- Data element separator, Asterisk, (*)
- Repetition Separator, Caret, (^)
- Component Element Separator, Colon, (:)
- Segment Terminator, Tilde, (~)

Dates

The following rules apply to any dates in the 834 Enrollment and 820 Payment transaction:

- For the 820 transaction, all dates will be formatted according to Year 2000 compliance, CCYYMMDD, except for the ISA09 element (Interchange date) where the date format is YYMMDD.
- The only value acceptable for "CC" (century) is 20. The exception to this rule is for any of the Date of Birth values.
- Time is in military time format, 1 to 24 to indicate hours and 00 to 59 to indicate minutes and/or seconds. ISA10 and GS05 elements are formatted HHMM.
- No spaces or character delimiters should be used in presenting dates or times.

Field Length

ASC X12 standards specify minimum and maximum field lengths for all of the data elements of the 834 Enrollment and 820 Payment transactions. The Transaction Specifications in Section 3 display the Exchange field lengths.

Phone Numbers

Phone numbers are presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (800) 555-1212 should be presented as 8005551212. Area codes should always be included.

2.3.3. Data Interchange Conventions

When transmitting 834 Enrollment and 820 Payment Transactions, Exchange follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or “outer envelopes”. All transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. Specific information on how individual data elements are populated by

Exchange on ISA/IEA and GS/GE envelopes are shown in the table beginning later in this section.

2.3.4. **Acknowledgement Procedures**

The Exchange requires that carriers send a response 999 Acknowledgement file for every inbound transaction received. The Exchange will not implement an 834 Effectuation File.

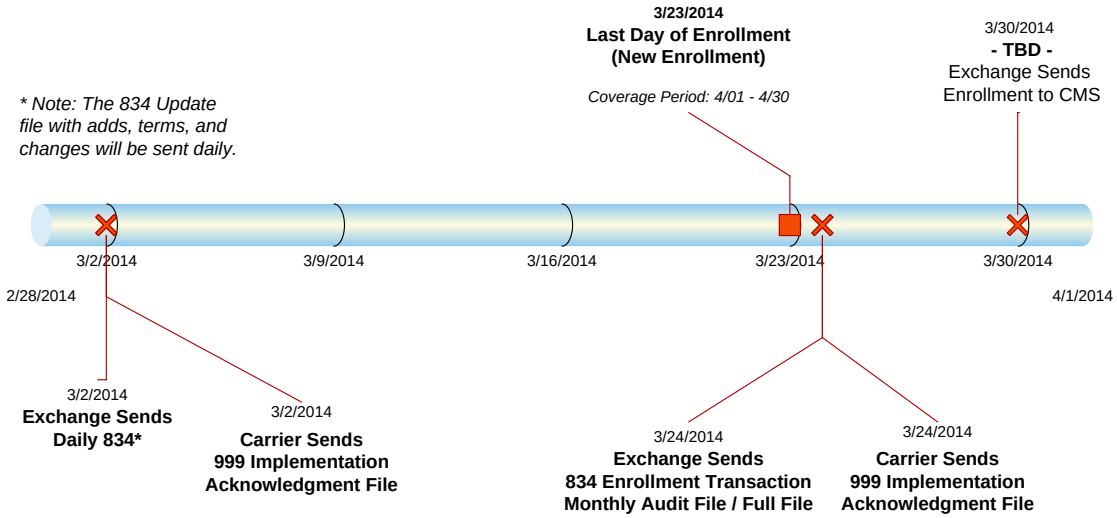
2.3.5. **Rejected Transmissions and Transactions**

Exchange will validate all 834 and 820 transactions up to HIPAA validate levels 1 and 2. If a receiver rejects any part of a transmission, they must reject the entire transmission. Data on rejected 834 and 820 transmissions should not be used to update health plan databases.

3. Enrollment

3.1. Enrollment Calendar

Washington Health Benefit Exchange
Individual Market Enrollment Schedule



3.2. Enrollment Transmission Schedule

The Exchange will send a monthly 834 Enrollment Audit file to carriers for each QHP. The Audit file will be sent on the first business day after the Enrollment Cutoff Date. The Exchange will send a daily 834 Update that includes adds, changes, and deletes.

The Exchange will send two files on the date the Audit file is sent. The first will be the daily 834 Update file and the second will be the Audit file. It is expected that carriers will process the 834 Update file prior to processing the Audit file. The files will have a naming convention that will differentiate the files.

The Exchange will send separate 834 Enrollment files for the individual market and the small group market.

3.3. Open Enrollment - Initial and Ongoing

The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. For the initial open enrollment period on or before December 23, 2013, the coverage effective date will be January 1, 2014. Between (and including) the 1st and 23rd day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month; Between the 24th and last day of the month for any month between December 2013 and March 31, 2014, the coverage effective date will be the first day of the second following month.

The carriers can expect to receive the first enrollment Update file on October 1st, 2013. The first full Audit file with be sent on October 24th, 2013.

For benefit years beginning on or after January 1, 2015, the annual Open Enrollment period begins October 15 and extends through December 7 of the preceding calendar year. Coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual Open Enrollment period.

For annual Open Enrollment periods with benefit years beginning on or after January 1, 2015, the first daily enrollment Update file will be sent on October 15th.

During enrollment, the Exchange will not send an enrollment transaction if the individual has not initiated payment. The initial payment must be submitted by the individual prior to confirmation of enrollment through the Exchange. However in the case that the initial payment is invalid, for example due to non-sufficient funds, the Exchange will send the Enrollment transaction through the daily 834 Update file and if the error is not corrected by the coverage start date, the Exchange will send a disenrollment transaction through the 834 Update file on or around the 1st of the month. The individual will have an Enrollment history of 'Cancelled' in the Exchange which indicates that their enrollment was never active.

During Open Enrollment, an individual or family can select and re-select a plan until the end of Open Enrollment. An individual can only update their enrollment selection during the Open Enrollment period as long as the current date is not after their coverage effective date. This rule is applicable for Initial Open Enrollment and Open Enrollment for benefit years beginning on or after January 1, 2015. The carrier will receive the initial Add enrollment transaction on the day that the individual selects and makes the initial payment for that plan (Plan A). The payment transaction will not be sent until the end of Open Enrollment once the plan selections have been finalized. If the individual or family decides to re-select and enroll in a different plan (Plan B), the Exchange will send a Disenrollment transaction to Plan A, and send an Add transition to Plan B. Plan A will never receive a payment transaction for the initial Add transaction which should minimize the enrollment and payment reconciliation process for carriers.

3.4. Eligibility for Enrollees

The Exchange will offer individuals a seamless eligibility and enrollment process into QHPs and other public health insurance programs, such as Washington Apple Health. A single portal will be used to determine eligibility for premium tax credits, cost-sharing reductions, and Washington Apple Health, which includes CHIP and Modified Adjusted Gross Income (MAGI) related Medicaid programs and will include real-time eligibility determinations and a single session enrollment process.

Individuals seeking health insurance coverage will complete a single statewide application. The single statewide application is in development and will be approved by the Secretary of the US Department of Health and Human Services (HHS) prior to its implementation. For those seeking eligibility for fully or partially subsidized health insurance, individuals will need to submit information about their income and tax filing status. Individuals wanting to

purchase health insurance without subsidies will not be required to report this information.

In general, the individual preferences as captured through the application, including language preference or communication preferences are specific to the Exchange and carriers will not be required to support these preferences. Other elements that are captured during the application process and that are also fields within the segments of the 834 or 820 file, including relationship to subscriber, will be passed on to the carrier.

Individuals will be determined eligible, conditionally eligible or denied for advance premium tax credit and for purchase of a QHP. Those determined conditionally eligible will have 90 days to provide additional documentation to verify their self-attested information included in their application. These individuals will supply additional documentation to verify their social security number, income, citizenship status, lawful presence, incarceration status or Tribal membership. Those determined conditionally eligible will be included in enrollment and payment transactions. Conditional eligibility status will not be reported to QHPs, but may result in changes or terminations at the end of the 90 day period.

Individuals will only be allowed to be enrolled in one QHP at a time. Furthermore, one of the eligibility requirements for those receiving advance premium tax credits is that the individual does not have access to other minimum essential coverage, including Medicaid, Medicare, TriCare, affordable Employer Sponsored Insurance and some VA benefits. There will, however, be instances where an individual is enrolled in Medicaid and a QHP for a limited duration. This will occur when there is a change of circumstance that moves an individual to Medicaid from an existing Advance Premium Tax Credit (APTC) enrollment. In these instances, Medicaid will remain the payer of last resort.

The Exchange will be the system of record for all eligibility and demographic information. Any changes in demographic information will need to be reported directly to the Exchange. Any changes in eligibility will be reported to carriers on the daily 834 Enrollment transaction.

3.5. Advance Premium Tax Credit (APTC) Enrollees

A carrier must agree to comply with the Exchange processes and procedures related to the administration, reconciliation, and reporting related to advanced payment of tax credits (45 CFR §155.340). If an individual is determined eligible for advance payments of the premium tax credit or cost sharing reductions, or if eligibility for those programs has changed, the Exchange will notify the carrier and transmit the information necessary for carriers to implement, discontinue, or modify the level of the advance payment of premium tax credits and cost-sharing reductions, including the dollar amount of the advance payment and the cost-sharing reductions eligibility category.

The Exchange will make eligibility determinations for APTC and cost sharing reductions (CSR). Individuals and families with incomes between 100% and 400% of the federal

poverty level may be eligible for APTC.[1] Individuals and families determined eligible for APTC will only receive the tax credit if they enroll in a QHP through the Exchange.

The individual will be informed of their eligibility for APTC, including the maximum APTC amount for which they are eligible, prior to shopping and selecting health insurance plans. Following selection of a QHP, the individual will be allowed to adjust the amount of APTC they want to apply to their monthly premium and receive the remaining balance when they file their federal taxes. The Exchange will report this amount to the carrier and federal government to facilitate the payment of the APTC amount from the federal government directly to the carriers.

The ACA identifies three CSR tiers for individuals between 100% to150% of the federal poverty level (FPL), between 150% to 200% FPL and 200% to 250% FPL who enroll in a silver level QHP. In addition, members of federally recognized Tribes with incomes below 300% FPL are eligible for zero cost sharing for any QHP in which they are enrolled. The 834 enrollment file will include details about which cost sharing reduction tier the enrolled individuals are eligible. The reimbursement for cost sharing reductions will come directly from the federal government to the carriers.

The Exchange will aggregate payments made directly to the Exchange, including individual payments and payments made by third party payers on behalf of the individual. The US Department of Health and Human Services will coordinate payments of the APTC and CSR directly with the carriers. As of the date of publication, the Exchange is awaiting additional guidance from HHS regarding the process for making APTC and CSR payments.

3.6. Native Americans

Carriers are expected to comply with all federally required laws and regulations specific to American Indians and Alaska Natives (AI/AN) in the ACA and other federal regulations, including but not limited to the following:

- Monthly special enrollment periods for AI/AN people to enroll in the Exchange;
- AI/AN enrollee able to change from qualified heath plan to another plan one time per month;
- No cost sharing for AI/AN enrollees with incomes under three hundred (300) percent of federal poverty level;
- No cost sharing for item or service furnished through Indian Health Care Providers;
- Health programs operated by the Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary; and
- Compliance with Indian Health Care Improvement Act Sections 206 and 408.

[1] Non-Citizens who are lawfully present and who are ineligible for Medicaid by reason of immigration status may be eligible for APTCs if their income is less than 100 percent of the federal poverty level.

3.7. Adds, Changes, and Disenrollments

Adds

For New Member Enrollment, an add event will be submitted through the daily 834 Update Enrollment File. For adds due to birth or adoption, see Section 4.2: Mid-month Enrollment and Disenrollment

For New Member Enrollment, Member's Effective Dates of Coverage will be as follows:

> For enrollment submitted between (and including) the 1st and the 23rd of the month, the coverage effective date will be the 1st of the following month.
>
> For enrollment submitted between (and including) the 24th and the end of the month, the coverage effective date will be the 1st of the second following month.

Changes

Change events will be submitted to change information including, but not limited to Last Name, First Name, SSN and Date of Birth, Gender, Marital Status and Address information. In the case of reporting multiple changes per individual, multiple records will be submitted and will not be consolidated into one record.

Disenrollments

Voluntary Disenrollment can occur when an enrollee chooses to initiate disenrollment through the Exchange web portal as a result of the enrollee obtaining other minimum essential coverage or when an enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period. The Disenrollment Date submitted on the 834 Transaction File will be the Last Date of Coverage for a Subscriber and/or Spouse or Dependent. For disenrollment due to a plan change for a reported birth or adoption special enrollment event, see Section 4.2: Mid-month Enrollment and Disenrollment

> Example: Subscriber is eligible on 8/31/2014 and no longer eligible on 9/1/2014. The Termination Date will be entered as 20140831.

Involuntary Disenrollment can occur when an enrollee fails to make their premium payment in a timely manner. See "Grace Period and Delinquency Process" section.

In the case of fraudulent or incorrectly reported data, the Exchange may terminate an enrollee's coverage back to the effective date of coverage. Fraudulent or incorrectly reported data will be handled manually or through the reconciliation process. Details of this process are to be determined.

3.7 Reenrollment

The Exchange will support reenrollment of health benefits during the annual Open Enrollment period or upon eligibility for a Special Enrollment period (See Section 4.1:

Special Enrollment Events) if the enrollee has satisfied all payment in arrears through the current period. If the individual is not current on an outstanding payment, the individual will not be eligible for reenrollment of coverage through the Exchange.

Similarly, for enrollees who have been terminated from coverage due to non-payment, the Exchange will support reenrollment of health benefits during the annual Open Enrollment period or upon eligibility for a Special Enrollment period only if the enrollee has satisfied all payment in arrears through the current period. For example, if an enrollee is terminated on 08/01/2014 due to non-payment of premium, to be eligible for Open Enrollment (10/15 - 12/07) the individual must pay any outstanding balance prior to 12/07. If the enrollee has a qualifying event (e.g. birth of a child) they may be eligible to enroll prior to the Open Enrollment period but must pay any outstanding balance prior to or before reenrolling at a future date.

Outstanding premium balances will be forgiven after twelve months have lapsed. The individual will then be eligible to purchase coverage through the Exchange without paying a past due balance.

The Exchange will not limit how many times an individual can reenroll during a calendar year due to the potential churn between Medicaid eligibility and subsidized or non-subsidized coverage through a QHP. There are many business scenarios where an individual loses and regains QHP coverage including a change in eligibility to or from Medicaid. In all cases, the Exchange will support reenrollment of QHP health benefits during the annual Open Enrollment period or upon eligibility for a Special Enrollment period only if the enrollee has satisfied all payment in arrears through the current period. Please note, individuals eligible for Medicaid or the Children's Health Insurance Program will not be prevented from enrolling in those programs if they have outstanding balances with a QHP in the Exchange.

3.8 Enrollee Correspondence

Below is a list of enrollee correspondence that the Exchange will be responsible for sending:

- **Eligibility Decision for Health Care Coverage notice:** The Exchange will send individuals an eligibility determination notice that specifies what programs the primary applicant and the other members of the household are eligible for including Medicaid, Apple Health for Kids, APTC, or QHP.
- **Upcoming Open Enrollment Deadline notice:** During Open Enrollment the enrollee will receive an Upcoming Open Enrollment Deadline notice which states the beginning and end date for Open Enrollment and prompts the enrollee to select and enroll in a Plan for the next coverage period. This correspondence will not be sent during the initial open enrollment period.
- **Upcoming Special Enrollment Deadline notice:** If an enrollee is eligible for a Special Enrollment Period and has not selected a plan, the Exchange will send the enrollee an Upcoming Special Enrollment Deadline notice to prompt them to return

to the Exchange to select and enroll in a plan. This notice also explains to the enrollee that if they do not update their plan selection they may be disenrolled from coverage.

- **Health Benefit Termination notice:** In a disenrollment scenario, the Exchange will send the enrollee a Health Benefit Termination notice which states the day that their coverage in an Exchange QHP will end or did end if retroactively disenrolled.
- **Yearly Advance Premium Tax Credit Summary notice:** The Exchange will provide enrollees who are eligible for APTC a yearly notice that summarizes the amount of APTC they received for the previous tax year.
- **Monthly Invoice:** The Exchange will invoice enrollees in the individual market on the 1st of the month prior to the month of coverage (electronic correspondence only).
- **Receipt of Payment:** The Exchange will generate a receipt of payment for individuals when enrollees make a premium payment through the Exchange.
- **Premium Payment Delinquency notice:** The Exchange will send a delinquency notice to the enrollee on the 1st of the month in which a payment for that month was not received.

4. Special Enrollment

4.1. Special Enrollment Events

Individuals will report qualifying events through the Exchange web portal. A qualified individual has 31 days to report the event and may then be determined eligible for a 60 day Special Enrollment period from the date of the qualifying event to select a QHP. In the case of reporting a birth or adoption, or placement for adoption, the household has 60 days to report the event. The Exchange will allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

1. A qualified individual or dependent loses minimum essential coverage (Note: This condition excludes loss of coverage due to non-payment of premiums by the individual but includes loss of coverage due to non-payment of premiums by an employer);
2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the Exchange or HHS error;
5. An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP.
7. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
8. An American Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
9. A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.
    - To comply with WAC 284-43-985(3)(a), enrollees under 19 will be eligible for special enrollment if losing employer sponsored insurance coverage for any reason.

The Exchange will monitor and manage special enrollment rules and will only send an enrollment transaction to the QHP once the individual or family has been determined eligible for a special enrollment period, and has selected a plan and initiated payment. In the case that a qualified individual elects to change from one QHP to another as a result of a qualifying event, the last day of coverage in the current QHP will be the last day of the first month prior to their coverage effective date in the new QHP, unless stated otherwise.

Unlike during Open Enrollment, during the Special Enrollment period once an individual or family selects and enrolls in a QHP they cannot change their enrollment. If an individual makes an enrollment decision and initiates payment for the plan they will be effectually enrolled based on the coverage start date that has been defined per Section 4, Special Enrollment.

4.2. Mid-month Enrollment and Disenrollment

The Exchange will support mid-month enrollment and disenrollment only in the case of a qualified individual gaining a dependent through birth, adoption, or death. Birth, adoption and death are the only Special Enrollment qualifying events that require a retroactive enrollment or disenrollment, except in the instance that an enrollee contacts the Exchange due to extenuating circumstances. Other qualifying events do not require a retro enrollment or disenrollment.

In the case of reporting a birth or adoption, the household has 60 days to report the event and will have a 60 day Special Enrollment period from the date of a triggering event to select a QHP.

In the case that an individual elects to change from one QHP to another as a result of a qualifying event, the effective end date of coverage in the current QHP will be the day prior to the qualifying event.

> Example: If the dependent of an enrollee is born on August 22nd, 2014 and the enrollee reports the qualifying event on September 12th, 2014, the effective date of coverage for the dependent will be August 22nd, 2014.

The Exchange will support mid-month terminations in the case of death. The effective end date of coverage will be the reported date of death.

Scenarios

Scenario 1: Mid-month Enrollment / Disenrollment -

- Change Reported: Added an individual due to birth / adoption or individual removed due to death. Includes: Plan Change (e.g. QHP(a) to QHP(b)), Affordability Program to QHP (e.g. Medicaid to APTC QHP / non-subsidized QHP))

Table 1: Special enrollment effective dates for birth, adoption, and death

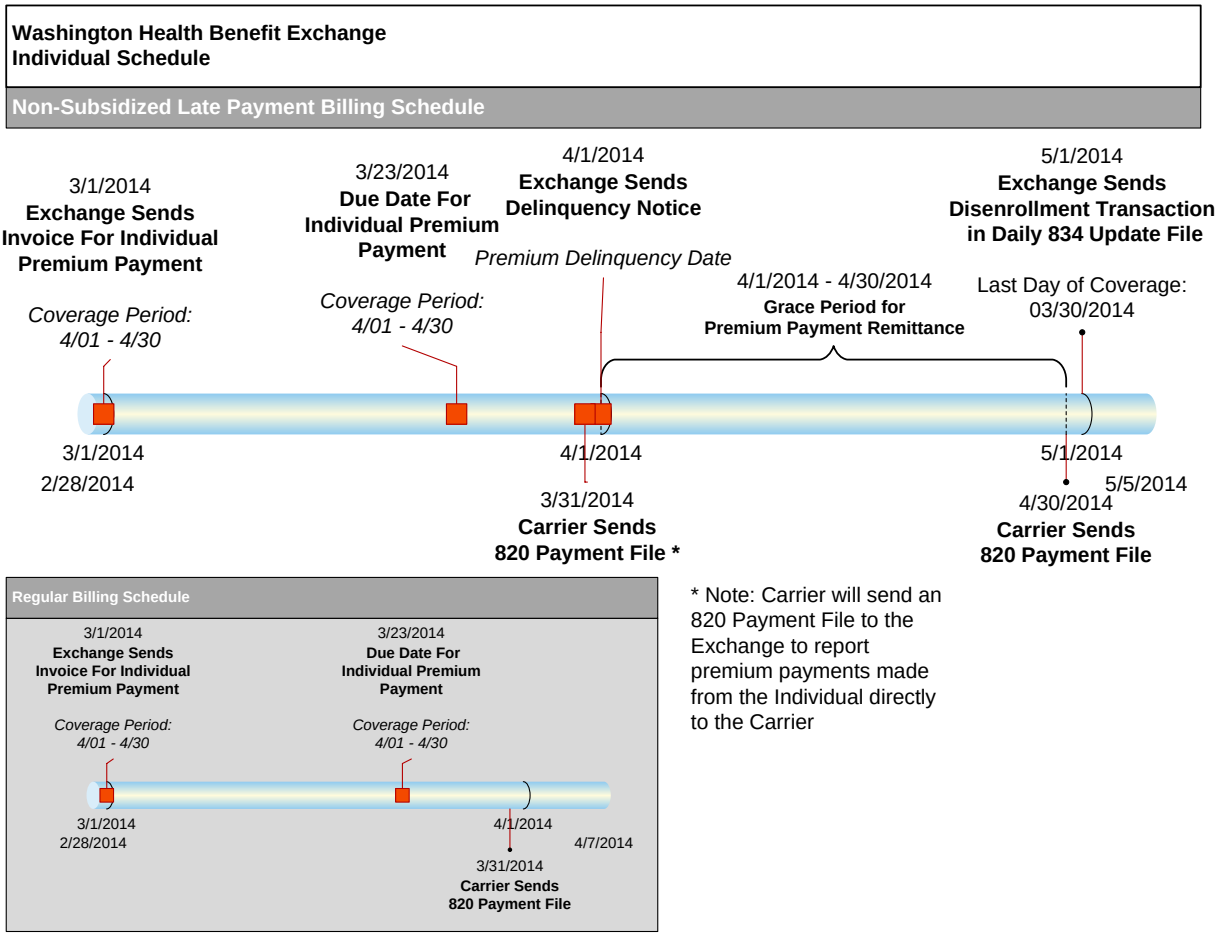
Change of Circumstance Type	Effective Disenrollment date	Effective Enrollment date
Income Change	Effective disenrollment date from current QHP is last day of the current month, if plan selected on or before 23rd of the month Effective disenrollment date from current QHP is last day of the of the next month, if plan selected after 23rd of the month	Effective enrollment date of QHP = 1st of the next month, if plan selected on or before 23rd of the month Effective enrollment date of QHP = 1st of the month following next month, if plan selected after 23rd of the month
Add a dependent due to birth, adoption, or placement for adoption	Effective disenrollment date from current QHP is the day prior to the date of event	Effective enrollment date of QHP is the date of event
Add a dependent due to marriage or loss of minimum essential coverage	Effective disenrollment date from current QHP is last day of the current month	Effective enrollment date of QHP is the 1st of the next month of the reported change.
Remove a dependent due to death *Assumption: There are additional householder members on the application after reported change	Effective disenrollment date from current QHP is the day prior to the date of event	Effective enrollment date of QHP is the date of event

5. Enrollee Billing

The Exchange will be responsible for generating all invoices to individuals. The invoice will also include any adjustments due to changes in enrollment. Each invoice will include both health and dental insurance purchased through the Exchange.

In the case of late payment, the Exchange will send a Delinquency Notice to the individual informing them of their late payment on the first day of the coverage month (or the first business day after the payment reconciliation transaction). This will begin the Grace Period and Delinquency Process described below.

5.1 Billing Calendar

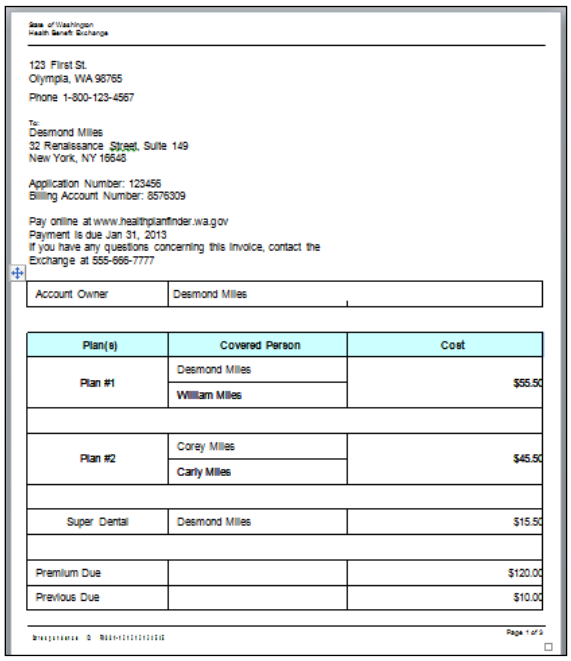


* Note: Carrier will send an 820 Payment File to the Exchange to report premium payments made from the Individual directly to the Carrier

5.2 Premium Collection Schedule

The Exchange will invoice enrollees in the individual market on the 1st of the month prior to the month of coverage. For example, an invoice will be sent on March 1st for the April 1st -30th coverage period. The individual payment is due on the 23rd of each month, i.e. March 23 in this example.

Example Exchange Enrollee Invoice:



State of Washington
Health Benefit Exchange

123 First St.
Olympia, WA 98765
Phone 1-800-123-4567

To:
Desmond Miles
32 Renaissance Street, Suite 149
New York, NY 16548

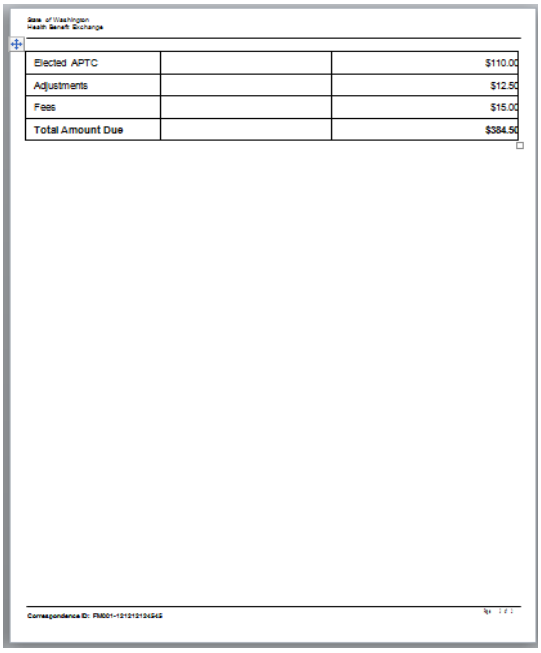
Application Number: 123456
Billing Account Number: 8576309

Pay online at www.healthplanfinder.wa.gov
Payment is due Jan 31, 2013
If you have any questions concerning this invoice, contact the Exchange at 555-666-7777

Account Owner	Desmond Miles

Plan(s)	Covered Person	Cost
Plan #1	Desmond Miles	$55.50
	William Miles	
Plan #2	Corey Miles	$45.50
	Carly Miles	
Super Dental	Desmond Miles	$15.50
Premium Due		$120.00
Previous Due		$10.00

Page 1 of 2



State of Washington
Health Benefit Exchange

Elected APTC		$110.00
Adjustments		$12.50
Fees		$15.00
Total Amount Due		$384.50

Correspondence ID: FM001-1212121243A5

Pg 1 of 2

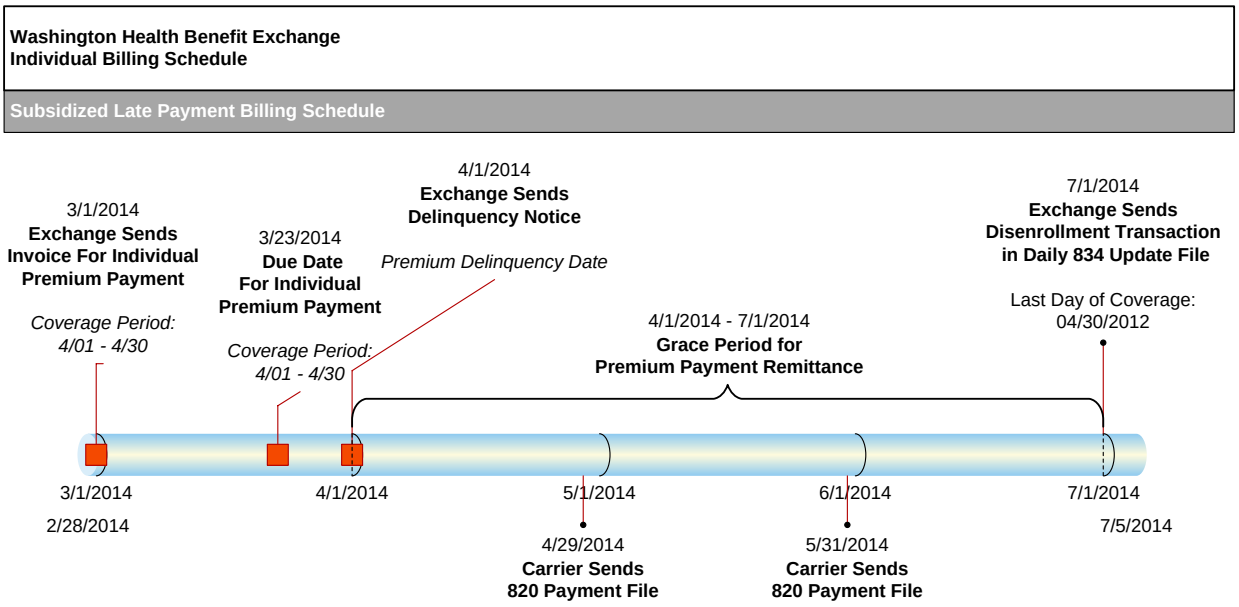
5.3 Mid-month Enrollment and Disenrollment (Pro Rated Premium Calculation)

Premiums will be prorated when a mid-month enrollment or disenrollment takes place due to birth, adoption, or death. The prorated premium will be based on the coverage end date and / or coverage begin date. For example, in the case of a mid-month enrollment due to birth, the coverage end date for the previous plan, Plan A, will be the day prior to the birth date of the child. The coverage effective date for the new plan, Plan B, will be the birth date of the child. The prorated premiums will be as follows: Plan A - day of coverage from the 1st of the month until the day prior to the birth date of the child. For Plan B, the prorated amount will be the birth date of the child until the end of the month.

5.4 Grace Period and Delinquency Process

The Exchange grants non-subsidized enrollees in the individual market a 1 month grace period beginning on the 1st of the month following a missed payment. The Exchange will send a Delinquency Notice to the enrollee on the 1st of the month following a missed payment. If the 1 month grace period for unsubsidized individuals has been exhausted, the last day of coverage will be the last day of the month prior to the 1 month grace period. A grace period can only be applied to enrollees who are current on their past month's premium payment and the Exchange will not allow consecutive or rolling grace periods.

> Example: If payment is due on 03/23/2014 and no payment has been received, the enrollee has a 1 month grace period beginning 04/01/2014 to make payment for the current month. On 04/30/2014 the premium payment for April and May is due in full. The enrollee will not be granted an additional grace period if the April and May premium payments are not satisfied by 04/30/2014.



The federal regulations require the Exchange to grant subsidized enrollees in the individual market a 3 month grace period beginning on the 1st of the month following a missed payment. The Exchange will send a Delinquency Notice to the enrollee on the 1st of the month following a missed payment. If the 3 month grace period for individuals receiving advance payment of the premium tax credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period. The QHP will be expected to pay claims during the first month of a grace period, but may suspend claims in the second and third months.

For subsidized enrollees, the QHP will be expected to pay claims during the first month of a grace period, but may suspend claims in the second and third months. The QHP cannot deny claims during the second and third months of the grace period. If the individual settles all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third months could be denied. QHP carriers must notify providers who submit claims that an enrollee is in the second or third month of the grace period and that a claim may be denied if the outstanding premiums are not paid in full.

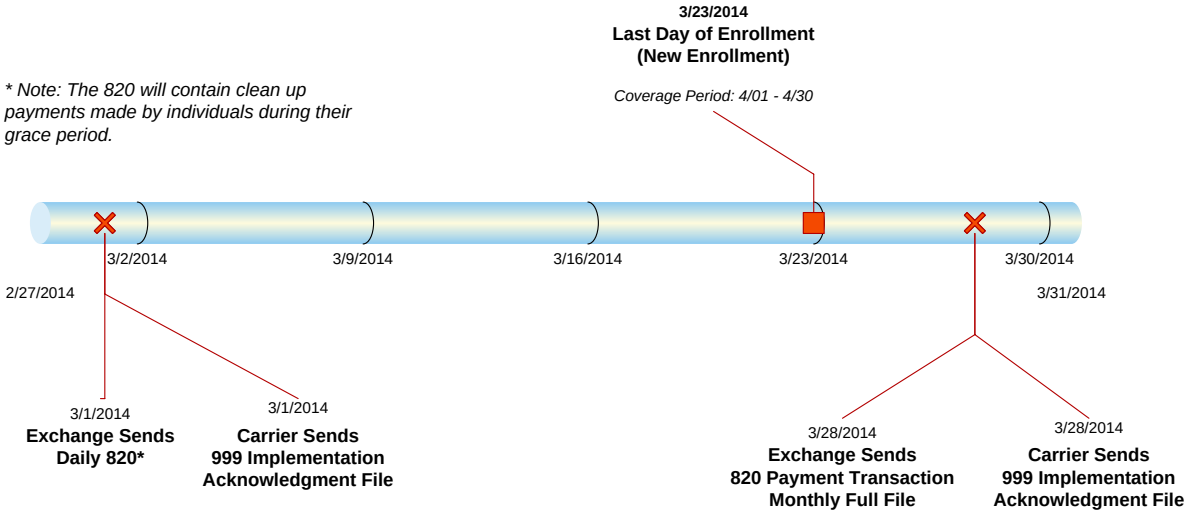
6. Payments

The Exchange will use our banking business partner, Key Bank to process payments. Key Bank will also be responsible for sending electronic payments to carriers on behalf of the Exchange. The invoice will require payment to be due on the 23rd day of the month preceding the month of coverage; however The Exchange will not initiate any delinquency action until at least the 1st day of the coverage month.

Individuals making payments online will be required to pay the full balance they owe, including any outstanding balance from previous months.

6.1. Payment Calendar

Washington Health Benefit Exchange
Individual Market Payment Schedule



6.2. Payment Transmission Schedule

The Exchange will collect and process premium payments from Individuals during Open Enrollment and on-going for monthly payments. The payments will be aggregated for carriers and paid to carriers once per month 5 business days after the Enrollment Cut-off Date for the following enrollment coverage period. An 820 ASC X12 file will be produced for each payment. Each carrier will receive a separate 820 file for each QHP within the Individual and/or SHOP market. Payments will include payments for all metal levels in a specific QHP.

The Exchange will collect and process premium payments initiated after the cutoff date and provide ACH payment and 820 reconciliation files to the carriers five business days following the cutoff.

6.3. Premium Payment to Carriers

The Exchange has selected Key Bank as their banking business partner. Key Bank will send premium payments to carriers on behalf of the Exchange using ACH transactions. The document number will be used to match ACH payment to the 820 transaction file.

6.4. APTC and CSR Payments

The Exchange originated 820 payment file will contain payment information about payments made directly to the Exchange by individuals and third party payers on behalf of individuals. The US Department of Health and Human Services will coordinate payments of the APTCs and CSRs directly with the carriers.

6.5 Carrier Receives Payment and Reports Payment to the Exchange

If the carrier receives a payment directly, then it is expected that they will process the payment and send notification of the payment to the Exchange via an 820 file by the end of the last day of the month. The Exchange will send acknowledgements for 820 files sent to them in the form of a 999. When payment notifications are received by the Exchange, the enrollee records will be updated and normal enrollment activities and notifications will occur.

7. Reconciliation Process

7.1. Reconciliation Schedule

The Exchange expects carriers to perform reconciliation on enrollment and payment data at least monthly.

7.2. Reconciliation Process

The monthly 834 Enrollment Audit File enables carriers to systematically compare QHP enrollment data with Exchange enrollment data and to identify discrepancies. The reconciliation process will allow the Exchange and carriers at a QHP level to identify potential member level enrollment data inconsistencies. If discrepancies exist between the Exchange file and the carrier system, the carrier is expected to internally resolve any discrepancies, and report any remaining unresolved discrepancies to the Exchange.

The following types of discrepancies will be identified and reported:

- Member is reported as actively enrolled by Exchange, but is not active with the QHP.
- Member is actively enrolled with QHP, but is not reported as active by Exchange.
- Member coverage information differs between the QHP and the Exchange (including date of birth, relationship code, plan type and address).
- Inconsistency in member enrollment and payment transactions

The Exchange will be using a Person ID that uniquely identifies each subscriber and dependent in the Exchange system. The Exchange will send this identifier in the 834 Enrollment file and the 820 Payment file. This identifier will ease reconciliation between the Enrollment and Payment transactions between the Exchange and its trading partners. Person ID will not be communicated by the Exchange to enrollees and should not be communicated outside of the Exchange-carrier business agreement.

7.2.1. Reporting Enrollment Discrepancies

The Exchange and carrier will work together to resolve any discrepancies. Depending on volume estimates, the Exchange will require a carrier to report discrepancies manually through a call to the Exchange account worker or through a consolidated list or report sent to an Exchange account worker.

Reconciliation between the Exchange and carriers is a manual process.

8. Transaction Specifications

8.1. 834 Enrollment Implementation Guide

The Exchange is implementing the ASC X12N/005010X220A1version of the implementation guide. This version is currently under public review. The Exchange will update this process guide when the approved version is released.

8.2. 820 Payment Implementation Guide

The Exchange is implementing the ASC X12N/005010X218version of the implementation guide. This version is currently under public review. The Exchange will update this process guide when the approved version is released.